



Psychology License by Endorsement Application Packet

This application is to be used by the following:

- Psychologists who have been licensed in another state or country for at least two years.
- Applicants who are a diplomate in good standing of the American Board of Examiners in Professional Psychology, now the American Board of Professional Psychology.

Contents:

1. 668-073 ... Contents List/SSN Information/Mailing Information	1 page
2. 668-074 ... Application Instructions Checklist	3 pages
3. 668-075 ... Psychologist License by Endorsement Application.....	5 pages
4. 668-041 ... Professional Reference Form	2 pages
5. 668-043 ... License Verification Form	2 pages
6. RCW/WAC and Online Web Site Links	1 page

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Board of Psychology Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

(This page intentionally left blank.)

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the forms required.

☐ **Application Fee.** This fee is non-refundable. You can check the online [fee page](#) for current fees.

☐ **1. Demographic Information:**

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

☐ **2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification, or Registration:**

List all states where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. You must provide documentation showing the licensure requirements at the time you were issued your credential. Attach additional completed pages if you need more space.

☐ **4. Professional Certifications:**

Please indicate if you are a diplomate in good standing with the American Board of Professional Psychology. If using the certification to apply, you must have official documentation sent to the department.

☐ **5. Education:**

- Fill out completely the date your program began, the name and location of institution granting doctoral degree, the type of doctoral program (e.g. clinical/ counseling, etc.), the date entered doctoral program which granted your doctoral degree date degree received (month/year), and the name and location of pre-doctoral internship.
- List in date order all institutions you attended, dates attended, date graduated, degree earned, major area of study, and number of semester/quarter hours earned. List your master’s thesis title and supervisor and the doctoral dissertation title and supervisor.
- Check your area(s) of professional competency.

☐ **6. Previous Application:**

Check yes or no whether you’ve taken a written or oral examination in psychology in the state of Washington or have ever been denied a license as a psychologist in the state of Washington.

☐ **7. AIDS Education and Training Attestation:**

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in [WAC 246-12-270](#).

☐ **8. Applicant’s Attestation:**

You must sign and date this for us to process the application.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at <http://www.doh.wa.gov/hsqa/professions/military/> and include supporting documentation with your application.

Jurisprudence Examination Information

The jurisprudence examination will be administered after the applicant has passed the Examination of Professional Practice in Psychology (EPPP), has completed their experience hours, and has met all requirements to be licensed. The examination consists of 25 multiple-choice questions. The exam is open book, administered monthly at the Department of Health.

Jurisprudence Examination Topics:

You should know and understand each of the following Washington statutes and rules and how they relate to the practice of psychology in the state of Washington.

[RCW 18.83 Psychology Law](#)

[RCW 18.130 Uniforms Disciplinary Act](#)

[RCW 70.02 Health Care Information Act](#)

[RCW 26.44 Abuse of Children](#)

[RCW 71.05 Mental Illness Act](#)

[RCW 74.34 Abuse of Vulnerable Adults](#)

[WAC 246-15 Whistleblower Complaints](#)

[WAC 246-12 Administrative Procedures & Requirements for Credentialed Health Care Providers](#)

[WAC 246-924 Psychology Rules](#)

[WAC 246-16 Standards of Professional Conduct](#)

The Web site for the score transfer information is: <http://www.asppb.org/>

(This page intentionally left blank.)

Background
Check
Stamp
Here

Date
Stamp
Here

Revenue: 0219010000

Psychologist License by Endorsement Application

Please type or print clearly. Follow the instructions provided. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

☐ Male
☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City

State

Country

Address

City State Zip County

Country

Phone (enter 10 digit #)

Fax (enter 10 digit #)

Cell (enter 10 digit #)

Email address

Mailing address (if different from above)

City State Zip County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

For Office Use Only

Issue Date _____ License # _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation..... ☐ ☐

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐
4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? .. ☐ ☐

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

- b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:

- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
- b. Diverted controlled substances or legend drugs? ☐ ☐
- c. Violated any drug law? ☐ ☐
- d. Prescribed controlled substances for yourself? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐

3. Other License, Certification, or Registration

List all jurisdictions, including Washington, where credentials are or were held. Verification is required on the form provided. Attach additional completed pages if you need more space.

State or Other Jurisdiction	Permanent or Temporary	License by Written and/or Oral Examination	License		Currently Active?
			Year Issued	Number	

4. Professional Certification

Are you a diplomate in good standing with the American Board of Professional Psychology? ☐ Yes ☐ No

5. Education

Name and location of regionally accredited institution granting doctoral degree

Type of doctoral program (e.g. clinical/counseling, etc.)

Date entered doctoral program which granted your doctoral degree

Date degree received (month/year)

Was your doctoral program internship APA, CPA, or APPIC approved? ☐ Yes ☐ No

Highest degree earned _____ Year _____

Was any master's level coursework approved as meeting doctoral level coursework? ☐ Yes ☐ No

Did you complete a doctoral dissertation? ☐ Yes ☐ No

List in date order the name and location of each college, university, or professional school attended, the time spent in each, and if a graduate, the year of graduation.

Name and Location of Institution	Dates		Date Graduated (mm/dd/yy)	Degree Earned	Major Area of Study	# of Semester/ Quarter Hours Earned
	From (mm/dd/yy)	To (mm/dd/yy)				

Check your areas of professional competency:

☐ Clinical/Counseling ☐ Neuropsychology ☐ Industrial/Organizational ☐ School/Educational

☐ Other (specify) _____

6. Previous Application

Have you ever taken a written or oral examination in psychology in the state of Washington? ☐ Yes ☐ No

Have you ever been denied a license as a psychologist in the state of Washington? ☐ Yes ☐ No

7. Aids Education and Training Attestation

- ☐ School curriculum
☐ Employer/Other

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand

I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicants Initials	Date

8. Applicant's Attestation

I _____, declare under penalty of perjury under the laws of the state of
(Name of Applicant)

Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW [18.130.170](#) and RCW [18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Original Signature of Applicant)

(This page intentionally left blank.)



Board of Psychology Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

Professional Reference Request

Type or Print Clearly

Note: Please be advised upon receipt of written request, this form may be released to the applicant. You may choose to provide the applicant with a copy of your completed form. However addresses and telephone numbers will not be released. This form may be duplicated. Qualifying supervised experience in a human subject research setting is only allowed for hours providing and obtaining supervision for those clinical services defined as the "practice of psychology" under RCW 18.83.010(1). All other research-related hours do not qualify for supervised experience.

The person asking you to complete this form is applying for licensure as a psychologist in Washington State. Applicants must provide documentation from supervisors that they have met the supervised experience requirements for licensure. This form identifies several categories of supervised experience. These categories are defined in rules adopted by the Examining Board of Psychology. These rules are found in the Washington Administrative Code (WAC) which can be searched on the following site: <http://apps.leg.wa.gov/wac/default.aspx?cite=246.924>. The rules for the four categories of supervised experience are as follows: WAC 246-924-049, "Practicum"; WAC 246-924-053, "Preinternship"; WAC 246-24-056, "Internship"; and, WAC 246-924-059, "Post-doctoral supervised experience."

If you are being asked to complete this form for an applicant because his/her original supervisor is deceased or cannot be located, please document that information below under Item 1., "Other." Provide as much of the requested information as appropriate given your position based on the information and records available to you at your facility or institution, including any personal knowledge of the applicant's supervised experience.

For each response below please attach any additional explanation if necessary.

_____ has applied for a license as a psychologist in the State of
(Name of Applicant)
Washington and has given your name as a reference. Please return directly to the address listed above.

Your Name

Organization	Position		
Address	City	State	Zip

1. Supervision Relationship to Candidate:

☐ Practicum ☐ Preinternship ☐ Internship ☐ Post-doctoral ☐ Professional Colleague

☐ Other (specify) _____

Title of applicant's position and name of organization: _____

Professional Reference Request (Cont.)

2. Describe briefly the applicant's duties as you knew them in the position listed above: _____
- _____
- _____
3. If you were a supervisor of the applicant's **practicum**, please complete the following:
- A. Dates of supervision: From _____ To _____
 - B. Total number of hours of practicum experience you supervised: _____ (300 hours are required.)
 - C. Were at least 100 hours of the 300 Practicum hours spent in supervision (see WAC 246-924-049 for the definition of "supervision" in the Practicum)? ☐ Yes ☐ No Number of hours: _____
4. If you were a supervisor of the applicant's **preinternship** experience, please complete the following:
- A. Dates of supervision: From _____ To _____
 - B. Total number of hours of preinternship experience you supervised: _____
 - C. For every 20 hours of **preinternship** experience was the following completed?
 - a. Was there at least two hours of regularly scheduled, formal face-to-face individual supervision that addresses the direct psychological services provided by the applicant? ☐ Yes ☐ No
 - b. At least two hours of other learning activities such as case conferences, seminars on applied issues, conducting cotherapy with a staff person including discussion of a case, and group supervision? ☐ Yes ☐ No
5. If you were a supervisor of the applicant's **internship** experience, please complete the following:
- A. Was the internship site APA accredited or approved by APPIC? ☐ Yes ☐ No
 - B. Dates of supervision: From _____ To _____
 - C. Total number of hours of internship experience you supervised: _____ (At least 1,500 hours are required.)
 - D. For every 40 hours of internship experience was the following completed?
 - a. At least two hours of regularly scheduled, formal face-to-face individual supervision that addresses the direct psychological services provided by the applicant? ☐ Yes ☐ No
 - b. At least two hours of other learning activities such as case conferences, seminars on applied issues, conducting cotherapy with a staff person including discussion of the case, and group supervision? ☐ Yes ☐ No
6. If you were a supervisor of the applicant's **post-doctoral** or other experience, please complete the following:
- A. Dates of supervision: From _____ To _____
 - B. Total number of hours of post-doctoral psychological work you supervised: _____
 - C. Total number of hours of face-to-face supervision you provided: _____
 - D. Was there one hour of supervision for every 20 hours of experience? ☐ Yes ☐ No

Professional Reference Request (Cont.)

7. Do you have any concerns in recommending this applicant for a license in the state of Washington for independent practice? ☐ Yes ☐ No If yes, please comment specifically. Include any other information you consider relevant.
-
-
-
-
8. Is there any other information about this candidate which you believe should be provided to the Examining Board of Psychology? ☐ Yes ☐ No If yes, please explain. _____
-
-
-
-

Select which category(ies) apply to you and mark the appropriate box(es):

- A. If you provided supervision for the applicant for his/her Preinternship, Internship, or Post-doctoral supervised experience, identify with the category of credentialing that applied to you at the time you provided the supervision. If you select "Other," identify your credential status under the applicable laws in your state or province.

- ☐ Psychologist with two years post-licensure experience.
- ☐ Psychiatrist with three years of experience beyond residency.
- ☐ Social worker, Mental Health, or Marriage and Family Therapist with five years post-licensure experience.
- ☐ Doctoral level psychologist with three years post-doctoral experience who is exempt from licensure under RCW 18.83.200.
- ☐ Other _____
-
-
-
-

License Number: _____ Date of Original License: _____

- B. If you provided supervision for the applicant for his/her Practicum, enter the following information about your position in that facility or institution where the Practicum occurred and any health profession credential you held at that time.

Position Title _____

Professional Reference Request (Cont.)

Health Profession Credential _____

Other _____

- C. If you have provided information because the applicant's supervisor is deceased or cannot be located, provide the following information.

Current position/title _____

Name of facility/institution where applicant obtained supervised experience _____

Your Signature: _____ Date: _____



Washington State Department of

Health

Board of Psychology Credentialing

P.O. Box 47877

Olympia, WA 98504-7877

360.236.4700

Examining Board of Psychology License Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have held a license/registration/certification. Instruct them to return the form directly to the address listed above. Make a copy of this form if you are licensed in more than one state and/or jurisdiction. Licensing agencies normally charge a fee to verify a license. Please check in advance to help expedite this process.

If you have a license with the Department of Health, you do not need to complete a verification form.

This form is not required of those credentials issued by Washington State.

Name: _____

Mailing Address: _____

City, State & Zip Code: _____

Any other names used: _____

License Number: _____ Date Issued: _____

Have the licensing agency return this completed form to the address above.

License Verification

(To be Completed by the State Psychology Board)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of licensed psychologist: _____

Authority providing verification: _____

Applicant was licensed by:

Written Examination: _____ Date: _____ Score: _____

Name of Examination: _____

Other Examination: _____ Date: _____ Score: _____

Name of Examination: _____

Is license current? ☐ Yes ☐ No Expiration Date: _____

Is this licensee considered to be in good standing in your state? ☐ Yes ☐ No

If "No," please attach explanation.

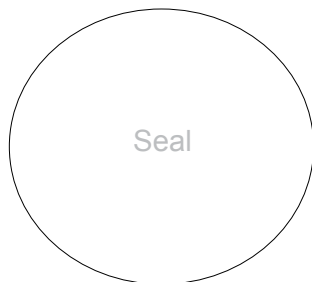
Has this license ever been:

Yes No

- | | | |
|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Denied |
| <input type="checkbox"/> | <input type="checkbox"/> | Suspended |
| <input type="checkbox"/> | <input type="checkbox"/> | Revoked |
| <input type="checkbox"/> | <input type="checkbox"/> | Surrendered |
| <input type="checkbox"/> | <input type="checkbox"/> | Reinstated |

If this licensee has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No

If yes, please provide a copy of the Final Order or other documentation of action taken.



Signature: _____

Title: _____

Date: _____



RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act.....	<u>RCW 18.130</u>
Administrative Procedure Act	<u>RCW 34.05</u>
Administrative procedures and requirements	<u>WAC 246-12</u>
Psychology RCW.....	<u>RCW 18.83</u>
Psychology WAC.....	<u>WAC 246-924</u>
Standards of Professional Conduct	<u>WAC 246-16</u>

On-Line

AIDS Training Resources	<u>Reference Page</u>
Board of Psychology.....	<u>Web Page</u>